STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR INC	45 BEACHWAY DRIVE INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaints IN00094814, IN00095455, IN00096396 and IN00096640. Complaint Numbers: IN00094814 - Substantiated, Federal/State deficiencies related to the allegations are cited at F223, F225, F226, F309. IN00095455 - Substantiated, Federal/State deficiencies related to the allegations are cited at F282, F312. IN00096396 - Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F223, F225, F226, F282, F312. IN00096640 - Substantiated, Federal/State deficiencies related to the allegations is cited at F323 Unrelated deficiencies cited. Survey dates: September 8, 9, 13, 14 & 16, 2011 Facility Number: 000032 Provider Number: 155077 Aim Number: 100273330	F0000	Submission of this plan of correction does not consititute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.This plan of correction is prepared and submitted because of requirements under state and federa law.Please accept this plan of correction as our credible allegation of compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Survey Team: Mary Jane G. Fischer, RN PHNS TC Census Bed Type: SNF: 24 SNF/NF: 128 Total: 152 Census Payor Type: Medicare: 26 Medicaid: 105 Other: 21 Total: 152 Sample: 10 Supplemental sample: 2 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on September 21, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified timely, in that when a family member noted a decline in the resident's condition, the nursing staff failed to notified the resident's physician for possible interventions for 1 of 10 residents reviewed for physician	F0157	1. The physician of Resident F was notified of medical concerns. Orders were received and resident F received treatment accordingly. The nurse making the entry, lacking communication to following shifts, was addressed and re-educated regarding appropriate follow up to family concerns and appropriate	10/07/2011

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	notification in the sample of 10. [Resident "F"]. Findings include: The record for Resident "F" was reviewed on 09-08-11 at 2:35 p.m. Diagnoses included but were not limited to cerebral vascular accident, hypertension, and diabetes mellitus. These diagnoses remained current at the time of the review. The resident had been readmitted to the facility after a brief hospitalization for a change in condition while visiting a family member. The hospital readmission discharge summary, dated 07-26-11, indicated the resident had a "history significant for recent embolic CVA [cerebral vascular accident] with residual left sided weakness after left femoral neck fracture and repair. Worrisome is the fact that [resident] has been dropping things from right hand and leaning to the right more. Patient should return to the hospital if temperature exceeds 101.5 F [Fahrenheit] or if dizziness, altered mental status, or syncopal episodes occur." Review of the nurses notes, dated 07-29-11 at 5:05 p.m. [Friday], indicated the following:		physician notification.2. As all residents have the potential to be affected, Nurse's Notes for the last 30 days for all residents were reviewed as well as records of residents re-admitted within the last 30 days in an effort to identify any concern(s) with physician notification and/or family concerns requiring follow up, and corrective action taken, as warranted.3. Licensed nursing staff have been re-educated on The Physician/Family Notification policy and procedure (see **attachment A)** and the Emergency Physician Notification procedure (see **attachment B**). Nurses have also been addressed in regard to response to family care concerns, including resident assessment and notification of appropriate supervisor(s) as to family concerns. In this manner, necessary investigation and interventions can be implemented, as warranted. In an effort to ensure ongoing compliance with timely physician and/or family notification, the DON or her designee will review 24-Hour Condition Reports and Nurse's Notes daily, on scheduled days of work, to ensure timely notification is made with change(s) in condition (see **attachment C**). Should concerns be noted, immediate corrective action shall be taken accordingly.4. As a means of quality assurance, the findings of	

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	"Resident [family member] has complaints about care resident is receiving, states [resident] is not being fed and turned like [resident] should, states [resident] has spoke with [name of Unit Manager Licensed Practical Nurse employee #2] and [name of Assistant Administrator employee #12] and feels no one is paying attention to concerns. [Family member] also states that [resident] mental status is decreasing, was notified about lab. [laboratory] and x-ray results, has questions about thyroid labs and stents to right brain feels as if [resident] is hemmorhagging <sic> again. physician faxed [facsimile]. Will pass on." The next nurses note entry, dated 08-01-11 at 11:10 p.m., indicated "Received a physician order which indicated "TSH [thyroid stimulating hormone] - hypothyroidism." During an interview on 09-13-11 at 8:30 a.m., the Assistant Director of Nurses employee #9 indicated the laboratory testing had not been completed and she spoke with the nurse practitioner on 09-12-11. The Assistant Director of Nurses indicated "since there was no diagnosis the order must have been a mistake."		the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action revised, if warranted.5. The above corrective measures will be completed on or before October 7, 2011.	

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	The record lacked any further documentation or follow up by the nursing staff related to the family concerns and as noted on 07-29-11 to the resident's physician. Review of facility policy on 09-13-11 at 12:40 p.m. at 12:40 p.m., titled "PHYSICIAN & FAMILY NOTIFICATION PROCEDURE," dated 01-06, indicated the following: "PURPOSE: To keep the physician, resident and family appraised of all condition changes." "PROCEDURE: Telephone: 1. Telephone notification is required for all emergencies or all condition changes that require an immediate response. 2. Notify the physician of any change in condition that any or may not warrant a change in the treatment plan [underscored]." "Faxing: 1. Document information to be faxed legibly and in black ink on a fax form that includes a statement of confidentiality. Include all assessment information that the physician will need to make his decisions. 2. If immediate physician response is required DO NOT FAX, call the physician [underscored]."			

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	This federal deficiency relates to Complaint IN00096396. 3.1-5(a)(2)			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse and potential physical abuse for 2 of 10 residents reviewed for abuse in the sample of 10. Residents I and A Findings include: 1. The record for Resident "I" was reviewed on 09-13-11 at 9:55 a.m. Diagnoses included but were not limited to Parkinson's disease, hypothyroidism, and depressive disorder. These diagnoses remained current at the time of the record review. During an interview on 09-13-11 at 9:30 a.m., the resident indicated "over the weekend I reported to the night nurse	F0223	1. (a) The involved employee was addressed as to failure to communicate a resident allegation. The nurse did not believe the resident to be reporting as an “allegation of abuse”; however, the nurse has been advised to report all statements/allegations to allow administrative staff to investigate and take corrective actions accordingly. (b) Resident I’s allegation was reported to ISDH as a reportable/unusual occurrence and investigated thoroughly, according to facility policy upon administrative notification of the same. (c)In regard to the concern of Resident A, the DON has been addressed as to thorough investigation of an allegation, including but not limited to, interview of various shifts and other potentially affected residents. Resident A’s responsible party was contacted by the Director of Nursing	10/07/2011

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	[Licensed Practical Nurse employee #28], that the aide [Certified Nurse Aide employee #29] wouldn't help me get up to go to the bathroom. She told me I would have to do it myself because she couldn't lift me, she had a 'bad back.' When I told her I couldn't and that I wasn't supposed to she told me she had a 95 year old grandmother who could take care of herself. This is the worse I have been talked to. I have Parkinson's and I don't walk and I don't try to get up on my own - I can't. I told the nurse but no one else has come to talk to me about it." During interview on 09-13-11 at 10:40 a.m., the Administrator and Assistant Administrator indicated they were unaware of the resident's allegation. 2. The record for Resident "A" was reviewed on 09-09-11 at 9:45 a.m. Diagnoses included but were not limited to congestive heart failure, diabetes mellitus, hypertension, atrial fibrillation, coronary artery disease and acute renal insufficiency. These diagnoses remained current at the time of the record review. Review of the nurses notes, dated 08-05-11 at 10:00 a.m., indicated the following: "Res. [resident] was reciving <sic> here		regarding follow-up to the investigation of the incident referenced in the citation.2. As all residents have the potential to be affected, Social Services conducted interviews of all interviewable residents to ensure any concerns related to staff treatment of residents were identified, communicated to administrative staff and investigated as per facility policy.3. As a means to ensure ongoing compliance with ensuring residents are free from verbal and potential physical abuse, staff have been re-educated on abuse, (see **attachment D**) and the facility Abuse policy (see **attachment E**). The Director of Social Services or her designee will interview 5 random interviewable residents weekly for 4 weeks, then 10 residents per month for 3 months, then quarterly thereafter to ensure any further issues are identified (see **attachment F**) and corrective action initiated should non-compliance with ensuring residents are free from verbal and/or potential physical abuse be noted.4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action will be reviewed/revised, if warranted.5. The above corrective measures will be	

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	<sic> medication and stated that her right ankle and knee was soar <sic>. [Name of physician] was here at the time, he looked at resident's leg and ordered a x-ray for right tib [tibia] / fib. [fibula] and ankle. Spoke with POA [power of attorney] to notify about x-ray and resident's condition. POA stated she wanted to be notified as soon as lab came in from x-ray. I put a note to the next nurse about labs being called to POA. Res. is in room in bed. Tylenol given at 10:00 a.m. and at 2:00 p.m. Still awating <sic> x-ray to come and lab results." Review of the x-ray result, dated 08-05-11, indicated "x-ray right tib/fibula right ankle - diagnosis trauma/pain." The nurses notes indicated the POA was notified of the x-ray results at 9:00 p.m. During interview on 09-14-11 at 10:12 a.m., the resident's POA indicated, "[resident' name] ankle swelled up great big. The ankle was bigger than the calf of [resident] leg. [Resident] said the lady was trying to get [resident] out of bed and that women pulled on it. I talked to the nurse and she said they would investigate it. No one has told me anything about the investigation." During interview on 09-14-11 at 11:20		completed on or before October 7, 2011.6. Please see attached addendum.	

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	a.m., the Director of Nurses indicated "I heard about [resident] ankle. I went down to [resident] room and [resident] said it happened either on night shift or when the day shift came in. [Resident] said the person hurt [resident]. I interviewed three staff members but no one knew anything." When queried if interviews included not only night shift but day shift as well, the Director of Nurses indicated, "no." When interviewed if other residents were interviewed, the Director of Nurses stated, "no." 4. Review of facility policy on 09-08-11 at 1:10 p.m., titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION POLICY AND PROCEDURE," and dated 01-06 indicated the following: "1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals." "4. Physical abuse - resident to resident abuse that results in injury, staff to resident abuse with or without injury, other (visitor, relative) to resident abuse with injury."			

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	"Verbal abuse - episodes of oral, written and/or gestured language that includes disparaging and derogatory remarks to residents. Staff to resident - a single traumatic episode, resident to resident verbal threats that cause distress to a resident." The federal deficiency relates to Complaint IN00094814 and IN00096396. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure staff reported allegations of abuse immediately to the administrator and failed to conduct interviews with day shift staff and	F0225	1. (a)The involved employee was addressed as to failure to communicate a resident allegation. The nurse did not believe the resident to be reporting as an “allegation of	10/07/2011

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	residents to ensure an allegation of physical abuse was thoroughly investigated. This deficient practice effected 2 of 10 sampled residents. [Residents "I" and "A"]. Findings include: 1. The record for Resident "I" was reviewed on 09-13-11 at 9:55 a.m. Diagnoses included but were not limited to Parkinson's disease, hypothyroidism, and depressive disorder. These diagnoses remained current at the time of the record review. During an interview on 09-13-11 at 9:30 a.m., the resident indicated "over the weekend I reported to the night nurse [Licensed Practical Nurse employee #28], that the aide [Certified Nurse Aide employee #29] wouldn't help me get up to go to the bathroom. She told me I would have to do it myself because she couldn't lift me, she had a 'bad back.' When I told her I couldn't and that I wasn't supposed to she told me she had a 95 year old grandmother who could take care of herself. This is the worse I have been talked to. I have Parkinson's and I don't walk and I don't try to get up on my own - I can't. I told the nurse but no one else has		abuse"; however, the nurse has been advised to report all statements/allegations to allow administrative staff to investigate and take corrective actions accordingly. (b) Resident I's allegation was reported to ISDH as a reportable/unusual occurrence and investigated thoroughly, according to facility policy upon administrative notification of the same. (c) In regard to the concern of Resident A, the DON has been addressed as to thorough investigation of an allegation, including but not limited to, interview of various shifts and other potentially affected residents. Resident A's responsible party was contacted by the Director of Nursing regarding follow-up to the investigation of the incident referenced in the citation.2. As all residents have the potential to be affected, Social Services conducted interviews of all interviewable residents to ensure any concerns related to staff treatment of residents were identified, communicated to administrative staff and investigated as per facility policy.3. As a means to ensure ongoing compliance with ensuring residents are free from verbal and potential physical abuse, staff have been re-educated on abuse, (see **attachment D**) and the facility Abuse policy (see **attachment E**) including reporting allegations immediately to the	

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	come to talk to me about it." During interview on 09-13-11 at 10:40 a.m., the Administrator and Assistant Administrator indicated they were unaware of the resident's allegation. 2. The record for resident "A" was reviewed on 09-09-11 at 9:45 a.m. Diagnoses included but were not limited to congestive heart failure, diabetes mellitus, hypertension, atrial fibrillation, coronary artery disease and acute renal insufficiency. These diagnoses remained current at the time of the record review. Review of the nurses notes, dated 08-05-11 at 10:00 a.m., indicated the following: "Res. [resident] was reciving <sic> here <sic> medication and stated that her right ankle and knee was soar <sic>. [Name of physician] was here at the time, he looked at resident's leg and ordered a x-ray for right tib [tibia] / fib. [fibula] and ankle. spoke with POA [power of attorney] to notify about x-ray and resident's condition. POA stated she wanted to be notified as soon as lab came in from x-ray. I put a note to the next nurse about labs being called to POA. Res. is in room in bed. Tylenol given at 10:00 a.m. and at 2:00 p.m. Still awating <sic> x-ray to		administrator and administration conducting of a thorough investigation. The Director of Social Services or her designee will interview 5 random interviewable residents weekly for 4 weeks, then 10 residents per month for 3 months, then quarterly thereafter to ensure any further issues are identified (see attachment F) and corrective action initiated should non-compliance with ensuring residents are free from verbal and/or potential physical abuse be noted.4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action will be reviewed/revised, if warranted.5. The above corrective measures will be completed on or before October 7, 2011.6. Please see attached addendum.	

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	come and lab results." Review of the x-ray result, dated 08-05-11, indicated "x-ray right tib. / fibula right ankle - diagnosis trauma/pain." The nurses notes indicated the POA was notified of the x-ray results at 9:00 p.m. During interview on 09-14-11 at 10:12 a.m., the resident's POA indicated, "[resident] ankle swelled up great big. The ankle was bigger than the calf of [resident] leg. [Resident] said the lady was trying to get [resident] out of bed and that women pulled on it. I talked to the nurse and she said they would investigate it. No one has told me anything about the investigation." During interview on 09-14-11 at 11:20 a.m., the Director of Nurses indicated "I heard about[resident] ankle. I went down to [resident] room and [resident] said it happened either on night shift or when the day shift came in. [Resident] said the person hurt [resident]. I interviewed three staff members but no one knew anything." When queried if interviews included not only night shift but day shift as well the Director of Nurses indicated, "no." When interviewed if other residents were interviewed, the Director of Nurses stated,			

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	"no." The federal deficiency relates to Complaints IN00094814 and IN00096396. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure their abuse prohibition policy was implemented, in that when a resident, and a resident's family member expressed concerns of verbal and alleged physical abuse, the administrative staff failed to ensure the allegations were thoroughly investigated. In addition, when a resident expressed concerns of verbal abuse to the Licensed Practical Nurse Night Shift Supervisor, the employee failed to report the incident of alleged abuse as outlined in the facility policy. This deficient practice effected 2 of 10	F0226	1. (a)The involved employee was addressed as to failure to communicate a resident allegation. The nurse did not believe the resident to be reporting as an “allegation of abuse”; however, the nurse has been advised to report all statements/allegations to allow administrative staff to investigate and take corrective actions accordingly. (b) Resident I’s allegation was reported to ISDH as a reportable/unusual occurrence and investigated thoroughly, according to facility policy upon administrative notification of the same. (c) In regard to the concern of Resident A, the DON has been addressed as to thorough investigation of an	10/07/2011

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	sampled residents. [Residents "I" and "A"]. Findings include: 1. The record for Resident "I" was reviewed on 09-13-11 at 9:55 a.m. Diagnoses included but were not limited to Parkinson's disease, hypothyroidism, and depressive disorder. These diagnoses remained current at the time of the record review. During an interview on 09-13-11 at 9:30 a.m., the resident indicated "over the weekend I reported to the night nurse [LPN-Employee # 28] the aide [Certified Nurse Aide- Employee # 29] wouldn't help me get up to go to the bathroom. She told me I would have to do it myself because she couldn't lift me, she had a 'bad back.' When I told her I couldn't and that I wasn't supposed to she told me she had a 95 year old grandmother who could take care of herself. This is the worse I have been talked to. I have Parkinson's and I don't walk and I don't try to get up on my own - I can't. I told the nurse but no one else has come to talk to me about it." During interview on 09-13-11 at 10:40 a.m., the Administrator and Assistant Administrator indicated they were		allegation, including but not limited to, interview of various shifts and other potentially affected residents. Resident A's responsible party was contacted by the Director of Nursing regarding follow-up to the investigation of the incident referenced in the citation.2. As all residents have the potential to be affected, Social Services conducted interviews of all interviewable residents to ensure any concerns related to staff treatment of residents were identified, communicated to administrative staff and investigated as per facility policy.3. As a means to ensure ongoing compliance with ensuring residents are free from verbal and potential physical abuse and to ensure the facility policy is implementing, staff have been re-educated on abuse, (see **attachment D)** and the facility Abuse policy (see **attachment E**). The Director of Social Services or her designee will interview 5 random interviewable residents weekly for 4 weeks, then 10 residents per month for 3 months, then quarterly thereafter to ensure any further issues are identified (see **attachment F**) and corrective action initiated should non-compliance with ensuring residents are free from verbal and/or potential physical abuse be noted.4. As a means of quality assurance, the findings of the above audits and any	

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	unaware of the resident's allegation. 2. The record for resident "A" was reviewed on 09-09-11 at 9:45 a.m. Diagnoses included but were not limited to congestive heart failure, diabetes mellitus, hypertension, atrial fibrillation, coronary artery disease and acute renal insufficiency. These diagnoses remained current at the time of the record review. Review of the nurses notes, dated 08-05-11 at 10:00 a.m., indicated the following: "Res. [resident] was reciving <sic> here <sic> medication and stated that her right ankle and knee was soar <sic>. [Name of physician] was here at the time, he looked at resident's leg and ordered a x-ray for right tib [tibia] / fib. [fibula] and ankle. spoke with POA [power of attorney] to notify about x-ray and resident's condition. POA stated she wanted to be notified as soon as lab came in from x-ray. I put a note to the next nurse about labs being called to POA. Res. is in room in bed. Tylenol given at 10:00 a.m. and at 2:00 p.m. Still awating <sic> x-ray to come and lab results." Review of the x-ray result, dated 08-05-11 indicated "x-ray right tib. / fibula right ankle - diagnosis trauma/pain."		corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action will be reviewed/revised, if warranted.The above corrective measures will be completed on or before October 7, 20116. Please see attached addendum.	

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The nurses notes indicated the POA was notified of the x-ray results at 9:00 p.m.

During interview on 09-14-11 at 10:12 a.m., the resident's POA indicated, "[resident's name] ankle swelled up great big. The ankle was bigger than the calf of [resident] leg. [Resident] said the lady was trying to get [resident] out of bed and that women pulled on it. I talked to the nurse and she said they would investigate it. No one has told me anything about the investigation."

During interview on 09-14-11 at 11:20 a.m. the Director of Nurses indicated "I heard about [resident] ankle. I want down to [resident] room and [resident] said it happened either on night shift or when the day shift came in. [Resident] said the person hurt [resident]. I interviewed three staff members but no one knew anything." When queried if interviews included not only night shift but day shift as well, the Director of Nurses indicated, "no." When interviewed if other residents were interviewed, the Director of Nurses stated, "no."

3. Review of facility policy on 09-08-11 at 1:10 p.m., titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION POLICY AND

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	PROCEDURE," and dated 01-06 indicated the following: "It is the policy of this facility that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority." "1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. "9. All reports of a use must be reported to the Administrator immediately and to the resident's representative (sponsor, responsible party) within 24 hours of the reporting or discovery of the incident." This federal deficiency relates to Complaints IN00094814 and IN00096396. 3.1-28(c)			

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F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure and protect the resident's dignity for 3 of 10 sampled and 2 of 2 supplemental sampled residents. [Resident "B", "G", "I", "L" and "K"]. Findings include" 1. During an observation on 09-08-11 at 1:00 p.m., Resident "K" was seated in a wheelchair adjacent to the doorway to the beauty shop. The resident stated to Certified Nurse Aide- Employee #17, "Can you take me in there [in reference to the beauty shop]?" With other residents and visitors passing by, the CNA stated to the resident "Don't you know how to say, please?" 2. During an observation on 09-13-11 at 12:25 p.m., Resident "G" was being toileted by CNA-Employee #7. As the resident remained on the commode, the CNA referred to the resident's buttocks as [resident's] 'booty.' The resident looked up at the CNA, but didn't say anything. 3. During observation on 09-09-11 at 7:55 a.m., Resident "B" indicated a need	F0241	1. Involved Staff were immediately re-educated upon facility notification of observed concerns.Residents B, G, I L and K have been assessed/addressed by social services to ensure each resident did not incur latent negative effects of the staff interactions described and/or to ensure care needs are being addressed by nursing staff. 2. As all residents have the potential to be affected, Social Services conducted interviews of all interviewable residents to ensure any concerns related to staff interaction with residents were identified and corrective action initiated, as warranted.3. As a means to ensure ongoing compliance with ensuring and protecting resident dignity, nursing staff were re-educated on Resident Rights (see **attachment G**) and appropriate resident interaction. The DON or her designee will make rounds twice daily on scheduled work days for 4 weeks, then twice weekly for 4 weeks, then weekly thereafter to ensure observations are made of staff to resident interactions, ensuring that residents are treated in a dignified manner (see **attachment H).** Should concerns be noted, immediate corrective action shall be taken. The	10/07/2011

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	for incontinence care. The nursing staff was notified and as the CNA pulled the linens from the resident, towards the end of the bed, a urinal was observed positioned between the resident's legs, with the penis inside the urinal. When interviewed, the resident indicated the urinal was there because the night shift didn't want [resident] to have an accident and be incontinent on the bedding. 4. During interview on 09-09-11 at 8:30 a.m., a concerned family member was seated in the main dining room, with Resident "G." The family member indicated the nursing staff frequently did not provide the resident with [resident] dentures. "I come in the morning just to make sure the dentures are in, wheelchair all the way up to the table and the sugar and that sort of thing has been opened." 5. During an interview on 09-09-11 at 8:20 a.m., Resident "L" indicated [resident] was at the facility for therapy. In addition, the resident indicated [resident] had previously worked there and some of the staff members mentioned they were going to check the resident's personnel file to see if there was any disciplinary actions, "fired" or "written up." I've never been fired or written up for anything. Some of the staff are nice but some are just plain hateful.		Director of Social Services or her designee will interview 5 random residents weekly for 4 weeks, then 10 residents per month for 3 months, then quarterly thereafter to ensure any further issues are identified (see **attachment F)** and corrective action taken, if warranted. 4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action revised, if warranted.5. The above corrective measures will be completed on or before October 7, 2011.6. Please see attached addendum.	

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	Sometimes I need help getting to the bathroom, they are slow in coming and I wet on myself." During this interview, a strong smell of urine permeated the air. 6. During an interview on 09-13-11 at 9:30 a.m., Resident "I" indicated "Once in a while I have an accident [incontinent of urine]. I don't like that happening, so I try to figure out who has me that day, what time their break is and what time they will be going home. That way I try to work my bathroom needs around their schedule." 7. Review of a section of the Resident Handbook, titled "Your Rights as a Nursing Home Resident," on 09-08-11 at 1:00 p.m., dated as 'revised 10-2010, indicated the following: "You keep all your fundamental civil or human rights and liberties when you are admitted to a nursing home. Basic Right: You have the right to be treated with respect and dignity in recognition of you individually and preferences. You have the right to quality care and treatment that is fair and free from discrimination." "Living Accommodations and Care - You have a right to: Receive care in a manner which promotes and enhances your quality of life."			

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	3.1-3(t)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure resident's plan of care were followed in that when residents were assessed as requiring total assistance with incontinence, repositioning and oral care, the facility failed to provide the appropriate services as outlined in the plan of care for 3 of 4 residents reviewed for activities of daily living in a sample of 10. [Residents "B", "F", and "J"]. Findings include: 1. The record for Resident "B" was reviewed on 09-09-11 at 11:50 a.m. Diagnoses included but were not limited to paraplegia, hypertension, and neurogenic bladder. These diagnoses remained current at the time of the record review. Review of the initial Minimum Data Set assessment indicated the resident was	F0282	1. The needs of Residents B, F and J were addressed as follows: a. Resident B's assignment sheet was reviewed/updated and caregivers re-educated as to routine incontinence needs/care .b. Resident F's physician was notified of missed lab draws and orders obtained and followed.c. Resident J's care plan was reviewed and revised, as indicated, to address incontinence care as well as oral care and staff were immediately re-educated.2. As all residents have the potential to be affected, the following corrective measures were taken:3. As a means to ensure ongoing compliance with the following of the plan of care for residents requiring total assistance with incontinence, repositioning, and oral care, Nursing staff were re-educated on nurse aide assignment sheet use-specifically as it relates to oral/dental care, incontinence care, and pressure ulcer prevention (see **attachments I and J**). The DON or her designee	10/07/2011

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	alert and oriented with no memory loss, incontinent of bowel and required extensive assistance with hygiene. The resident's plan of care, dated 07-15-11, indicated the resident "requires up to extensive/2 assist in performing ADL's [activities of daily living] due to paralysis, pain, weakness, incontinency, C5 - C7 [cervical] spinal cord injury. Extensive assist with transfers, toileting, bed mobility and set <sic> for meals." Interventions to the plan of care included "provide pericare each shift and after each incontinent episode." During an observation on 09-09-11 at 7:55 a.m., the resident was observed lying in bed. A pungent odor permeated the air. The resident stated "I'm soiled - I need to be changed." The resident indicated the last time someone came to the room to check and change for incontinence was "around 4:00 a.m." The licensed nurse was notified, who instructed an unidentified CNA to clean the resident. The CNA entered the room, without supplies and the resident indicated "I need to be changed." The CNA responded "what [pause] like linens?" The resident stated "No, I'm dirty, I need to be changed." The CNA responded "oh." The resident further instructed the CNA "you know like washcloths, pads,		will make rounds twice daily on scheduled work days for 4 weeks, then twice weekly for 4 weeks, then weekly thereafter to ensure observations are made of residents in need of said care and confirm said care is provided in a timely manner and per the plan of care (see **attachment K**) and corrective action taken, as warranted.4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action revised, if warranted.The above corrective measures will be completed on or before October 7, 2011	

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	everything you need to change me." The CNA indicated "OK I'll be right back." A few minutes later three CNA's entered the resident's room, CNAs - Employees #14 #15 and #16. CNA [#16] pulled the bedcovers down toward the end of the bed. The resident had a urinal positioned between legs. When interviewed, the resident indicated the urinal was put there by the night shift aide so "I didn't get the bed wet if I urinated." CNA [#16] turned the resident to the left side and as the resident was turned stool could be observed on the resident's bilateral buttocks and the incontinent pad. 2. The record for Resident "F" was reviewed on 09-08-11 at 2:35 p.m. and again on 09-13-11 at 10:00 a.m. Diagnoses for Resident "F" included but were not limited to cerebral vascular accident, diabetes mellitus, syncope, and hypertension. These diagnoses remained current at the time of the record review. The resident had been seen at a local hospital and returned to the facility with a letter from the radiology department, dated 07-01-11, which instructed the nursing staff as follows: "We will need Anesthesia clearance and recent blood work results for you prior to the procedure. I have enclosed an order			

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	for blood work. Please call the Pre-Op Clinic here at [name of hospital] to make an appointment. Please try to get in for this at least 1 week prior to your procedure." The laboratory blood work indicated included a Basic Metabolic Panel, a Complete Blood Count with Differential, and Activated PTT, Anesthesia clearance and a Prothrombin Time with INR [international normalization ratio]. During an interview on 09-09-11 at 11:20 a.m., the Unit Manager, Licensed Practical Nurse-Employee #2, indicated "[Name of resident] had orders to go out 08-30-11 for a cerebral angioplasty. The labs [laboratory work - blood tests] were scheduled to Monday [08-20-11]. The labs were not drawn and I didn't notify the physician." The nurse indicated she did not read the instruction letter that indicated the need for the testing to be completed at least 1 week prior to the procedure. The resident had been readmitted to the facility after a brief hospitalization for a change in condition while visiting a family member. The hospital readmission discharge summary, dated 07-26-11, indicated the resident had a "history significant for recent embolic			

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	CVA [cerebral vascular accident] with residual left sided weakness after left femoral neck fracture and repair. Worrisome is the fact that [resident] has been dropping things from right hand and leaning to the right more. Patient should return to the hospital if temperature exceeds 101.5 F [Fahrenheit] or if dizziness, altered mental status, or syncopal episodes occur. New order: Consults - Thyroid Consult, Nurse/staff to schedule an appointment within 1 month for follow-up of thyroid nodule found on carotid dopplers." The resident's record included a physician order, dated 08-01-11, which instructed the nursing staff "TSH [thyroid stimulating hormone laboratory test] - hypothyroidism." During interview on 09-13-11 at 8:30 a.m., the Assistant Director of Nurses-Employee #9 indicated the laboratory testing had not been completed and she spoke with the nurse practitioner on 09-12-11. The Assistant Director of Nurses indicated "since there was no diagnosis the order must have been a mistake." When interviewed if the discharge summary had been reviewed for the concern of the nodule as indicated on the carotid dopplers and a thyroid consult was needed, the Assistant Director of			

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	Nurses stated, "I didn't see that." Review of facility policy on 09-13-11 at 12:40 p.m., titled "Re-Admission Procedure [bold type and underscored], undated, indicated the following: "PURPOSE: To provide accurate documentation of the mental and physical condition of each resident re-admitted to the facility after a minimum of a 23 hour hospital stay or up to a maximum of 15 day hospital stay (or resident did not pay to hold bed)." "PROCEDURE: PHYSICIAN ORDERS - Upon admission, physician orders must be obtained as follows: Transcribe the re-admission order from the original sent from the hospital or physicians office. Labs - complete ancillary orders." "SCHEDULED APPOINTMENTS - 1. Check transfer sheet for outside scheduled appointments and place on calendar." 3. The record for Resident "J" was reviewed on 09-09-11 at 2:15 p.m. Diagnoses for resident "J" included but were not limited to schizophrenic condition, bipolar disorder and dementia with agitation. These diagnoses remained current at the time of the record review.			

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During the Initial tour of the facility on 09-08-11 at 10:30 a.m., Resident "J" was assessed by the Unit Manager Licensed Practical Nurse-Employee #4 as "total care."

Review of the resident's plan of care, dated 08-18-11, indicated the resident required assistance with activities of daily living due to total dependence for bed mobility, transfers, eating and toilet use.

The resident's plan of care for Urinary Incontinence, dated 08-18-11, indicated the resident was incontinent of bladder and required the nursing staff to "approach resident at least every two hours and ask and or check for evidence of incontinence."

The resident's plan of care, titled "Dental Care" and dated 08-18-11, indicated the resident "requires special attention to oral care due to edentulous <sic>, dependent on staff for oral care and impaired cognition." Interventions to this plan of care included "provide and assist with oral care daily and as needed."

A plan of care, dated 08-18-11, indicated the resident was at risk for pressure ulcers due to "dependence on staff for bed mobility, transfers and repositioning."

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	Interventions to this plan of care included "encourage and assist resident with turning and repositioning at least every two hours. Provide incontinent care after each incontinent episode." During an observation on 09-09-11 at 8:15 a.m., the resident was seated in a wheelchair in room. The resident cried and moaned. Upon entering the resident's room, the resident's tongue/mouth was observed coated with a thick white substance. The Assistant Director of Nurses was notified, who in turn instructed a CNA to provide oral care to the resident. The CNA exited the resident's room, and returned with toothettes. As the CNA provided oral care to the resident, thick white clumps were removed from the resident's tongue and oral cavity. Further observation at 10:10 a.m., the resident remained seated in the wheelchair. A request was made to check the resident for incontinence. CNA- Employee #16 indicated the resident was "up and in the wheelchair since about 7:30 a.m." The CNA pulled down the front of the resident's slacks and indicated the resident was "dry." A request was made to transfer the resident into bed to check skin.			

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	CNAs-Employees #14 and #16 exited the resident's room and approximately 10 minutes later returned with the mechanical lift. The CNA's positioned the lift in front of the wheelchair, fastened the appropriate hooks onto the sling that was already positioned beneath the resident, and then transferred the resident to bed. The CNA's removed the resident's slacks, unfastened the incontinent brief, and a strong smell of urine permeated the air. The resident was wearing one incontinent brief inside of the other and the inner brief was saturated and heavy with urine. The CNA's indicated they were unaware the resident had been placed in two incontinent briefs. This federal deficiency relates to Complaints IN00095455 and IN00096396. 3.1-35(g)(2)			
F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			

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	Based on record review and interview, the facility failed to ensure the nurses provided and documented accurate and ongoing assessment, in that when a resident was identified with a history of congestive heart failure, pneumonia and lower extremity edema and required additional diuretics to treat the resident's signs and symptoms, the nursing staff failed to recognize the resident's ongoing respiratory distress and decline in condition over a period of 11 days which resulted in the resident being transferred to the hospital with volume overload and pulmonary edema. This deficient practice effected 1 of 3 residents reviewed for edema in a sample of 10. [Resident "A"]. Findings include: The record for resident "A" was reviewed on 09-09-11 at 9:45 a.m. Diagnoses included but were not limited to congestive heart failure, diabetes mellitus, hypertension, atrial fibrillation, coronary artery disease and acute renal insufficiency. These diagnoses remained current at the time of the record review. The resident had physician orders originally dated 04-11-11 for Lasix [a diuretic] 40 mg. [milligrams] 3 tablets (120 mg) by mouth every morning and 2 tablets (80 mg) every evening.	F0309	1. Resident A was treated at the hospital for her decline in condition.2. As all residents have the potential to be affected, Nurse's Notes for the last 30 days were reviewed to ensure a complete and thorough assessment was conducted for any resident exhibiting a change/decline in condition warranting need of ongoing assessment. Any concerns noted were reviewed with the applicable nurse and re-education provided.3. As a means to ensure ongoing compliance with the provision of documented, accurate and ongoing assessment for residents exhibiting a decline and/or change in condition, Licensed nursing staff were re-educated on Nursing Charting policy, specifically pertinent charting and assessment to be completed with changes in condition or unstable conditions (see **attachment L**). The DON or her designee will review 24-Hour Condition Reports and Nurse's Notes daily, on scheduled work days, to ensure appropriate and thorough assessment is made, intervention sought if warranted, and the same documented (see **attachment C**). Should concerns be noted, immediate corrective action shall be taken.4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's	10/07/2011

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	Review of the resident's plan of care, dated 06-29-11, indicated the resident "requires use of oxygen at 2 liters per nasal cannula due to congestive heart failure, chronic obstructive pulmonary disease and pneumonia to keep sats [oxygen saturation] level greater that 90 %." Interventions to this plan of care included Duoneb [a respiratory treatment] every 6 hours, use oxygen at 2 liters per nasal cannula." The plan of care related to COPD, and dated 06-30-11, indicated the resident was at risk for respiratory distress. Interventions included "observe for signs and symptoms of respiratory distress, elevate HOB [head of bed] as needed to facilitate respiratory effort, administer oxygen as ordered, administer medications as ordered, advise the charge nurse if signs or symptoms are noted for further evaluation and possible physician and responsible party notification." Review of the nurses notes, dated 08-17-11 at 1:00 p.m., indicated the following: "Res. [resident] c/o [complained of] leggs <sic> being tight, upon assessment legs were swollen and tight. Called MD [Medical Doctor], new orders for increased Lasix [a diuretic] to 10 mg		quarterly Quality Assurance meetings and the plan of action revised, if warranted.5. The above corrective measures will be completed on or before October 7, 2011.	

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	[milligrams] BID [two times a day] times 3 days. POA [power of attorney] notified about medication changes, resident aware. Will continue to monitor for s/s [signs and symptoms] of infection and adverse reactions. Will follow plan of care." The next nurses note entry was dated 08-28-11 at 5:00 a.m., 11 days later, which indicated the following: "Pt. [patient] states having spell. c/o stomach hurting. tylenol [an analgesic] given for pain, was effective." Nurses note 08-29-11 1:00 a.m., "Pt. c/o stomach <sic> pain and not being able to lay in bed. Resident was given tylenol and sat in wheelchair. Resident also given [illegible word]. Both meds [medications] were effective." Review of the Respiratory therapist notations for 08-30-11 at 6:30 a.m., indicated the resident's oxygen saturation level was 69 - 70 %. The therapist placed oxygen on the resident and turned to level to 5 lpm [liters per minute]. The therapist documented the resident's oxygen level was checked 30 minutes later and the oxygen level had increased to 88 % and then a later notation indicated oxygen level was recorded at 92 %. Breath sounds were "diminished."			

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	Nurses note dated 08-30-11 at 8:00 a.m. Awake, up in wheelchair. O2 [oxygen] saturation 84 % on RA [room air]. Lungs course/dim. [diminished]. O2 [oxygen] places <sic. at 2L [liters]. Slight confusion. 1+ pedal edema. O2 sat recheck <sic> at 1 hr. [hour] 89% - O2 at 2L. MD [Medical Doctor] notified. Family notified. N.O. [new order] received to send out to [name of local area hospital]." A respiratory therapist notation on 08-30-11 at 11:30 a.m., also indicated the resident's breath sounds remained "diminished." "Pt. [patient] continues to "de sat [unable to keep oxygen level up] Resident is going to the hospital." During an interview on 09-14-11 at 12:30 p.m., Respiratory Therapist- Employee #21 indicated the following: "I went in to do a treatment and I put the probe on [resident's name] finger. [Resident] O2 Sat. [oxygen saturation level] was 69 % - 70 %. I put the oxygen on [resident] at 2 liters. I rechecked the O2 Sat. and it came up to 88 % - 90 %. It kept dropping a little bit. I went out to tell the nurses, they were in report. She [in reference to the nurse] went to call the MD [Medical Doctor]. I worked with [name of resident] 30 - 40 minutes. I finally got it [in reference to the oxygen			

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	saturation level] up in normal range and I left and went on to do what I had to do - the next treatment. After that I went back. Toward the end of the treatment [resident's family member] came in and the nurse said that after [name of resident] ate lunch she was going to send [resident] out [in reference to the hospital]. I told [name of nurse] that [name of resident] wasn't acting right." During an interview on 09-14-11 at 10:12 a.m., a concerned family member indicated, "[Resident] kept coughing and coughing. It was a real deep cough. This happened before in April and it seemed just like the same thing all over again. They told me they would give [resident] additional Lasix, but it didn't seem to help." The Medication Administration Record indicated the resident received the additional dosage of Lasix as ordered by the physician from 08-17-11 at 7:00 p.m. through 08-20-11 at 7:00 p.m. Review of the hospital History and Physical, dated 08-30-11, indicated the following: "... presents to hospital via EMS [emergency medical system] from the nursing home with worsening dyspnea and lower extremity edema. [Resident] is			

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	short of breath ... coughing ... was hypoxic and has been placed on BiPAP [breathing treatments] per the emergency room physicians. the chest x-ray show bibasilar infiltrates and pulmonary edema ... is grossly volume overloaded ...has an elevated white count. There is concern for coexistent pneumonia and had abdominal discomfort as well. [Resident] has progressive lower extremity edema and abdominal swelling. Lungs: very coarse and crackly without wheezes, very diminished in the bases bilaterally. Abdomen: markedly distended but non tender. Probably has ascites - and most likely related to edema. [Resident] has abdominal wall edema. Extremities: There is 3+ lower extremity edema to the thighs bilaterally. Assessment: The patient has acute on chronic respiratory failure. The etiology is not quite clear and is probably multifactorial, including at least in part some component of congestive heart failure, pulmonary edema, pleural effusions, possible superimposed pneumonia and COPD exacerbation." Review of the hospital cardiology consult report, dated 08-30-11, indicated "Today [resident] is short of breath ... coughing. [Resident] is grossly volume overloaded. On admission, [resident] blood pressure was tenuous with systolics running in the			

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	80's to 90's. [Resident] has abdominal discomfort as well. In addition, has an elevated white count and a venous lactate of 3. This would raise concern for impending sepsis as well." This federal deficiency relates to Complaint IN00094814. 3.1-37(a)			
F0312 SS=E	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure activities of daily living were provided for dependent residents, in that when residents were assessed as requiring total assistance with incontinence, repositioning and oral care, the facility failed to provide the appropriate services for 4 of 4 residents reviewed for activities of daily living in a sample of 10. [Residents "B", "F", "G", and "J"]. Findings include: 1. The record for Resident "B" was reviewed on 09-09-11 at 11:50 a.m. Diagnoses included but were not limited	F0312	1. The needs of Residents B, F and J were addressed as follows: a. b. and c. Residents B, F and G's assignment sheets were reviewed/updated and caregivers re-educated as to routine incontinence needs/care .a. Resident J's care plan was reviewed and revised, as indicated, to address incontinence care as well as oral care and staff were immediately re-educated.2. As all residents have the potential to be affected, the following corrective measures were taken:3. As a means to ensure ongoing compliance with the following of the plan of care for residents requiring total assistance with incontinence, repositioning, and oral care,	10/07/2011

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	to paraplegia, hypertension, and neurogenic bladder. These diagnoses remained current at the time of the record review. Review of the initial Minimum Data Set assessment indicated the resident was alert and oriented with no memory loss, incontinent of bowel and required extensive assistance with hygiene. The resident's plan of care, dated 07-15-11, indicated the resident "requires up to extensive/2 assist in performing ADL's [activities of daily living] due to paralysis, pain, weakness, incontinency, C5 - C7 [cervical] spinal cord injury. Extensive assist with transfers, toileting, bed mobility and set <sic> for meals." Interventions to the plan of care included "provide pericare each shift and after each incontinent episode." During an observation on 09-09-11 at 7:55 a.m., the resident was observed lying in bed. A pungent odor permeated the air. The resident stated "I'm soiled - I need to be changed." The resident indicated the last time someone came to the room to check and change for incontinence was "around 4:00 a.m." The licensed nurse was notified, who instructed an unidentified CNA to clean the resident. The CNA entered the room, without		Nursing staff were re-educated on nurse aide assignment sheet use-specifically as it relates to oral/dental care, incontinence care, and pressure ulcer prevention (see **attachments I and J).** The DON or her designee will make rounds twice daily on scheduled work days for 4 weeks, then twice weekly for 4 weeks, then weekly thereafter to ensure observations are made of residents in need of said care and confirm said care is provided in a timely manner and per the plan of care (see **attachment K**) and corrective action taken, as warranted. 4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action revised, if warranted.5. The above corrective measures will be completed on or before October 7, 2011.	

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	supplies and the resident indicated "I need to be changed." The CNA responded "what [pause] like linens?" The resident stated "No, I'm dirty, I need to be changed." The CNA responded "oh." The resident further instructed the CNA "you know like washcloths, pads, everything you need to change me." The CNA indicated "OK I'll be right back." A few minutes later three CNA's entered the resident's room., CNAs- Employees #14 #15 and #16. CNA #16 pulled the bedcovers down toward the end of the bed. The resident had a urinal positioned between legs. When interviewed, the resident indicated the urinal was put there by the night shift aide so "I didn't get the bed wet if I urinated." CNA #16 turned the resident to the left side and as the resident was turned stool could be observed on the resident's bilateral buttocks and the incontinence pad. CNA #16 proceeded to use wipes to clean the stool from the resident's rectal area. The resident's scrotum was red in color. CNA #14 proceeded to wet a washcloth and handed the wetted washcloth to CNA #16. The CNA wiped the resident's buttocks and rectal area, turning the soiled cloth after each wipe. The CNA used a towel to dry the resident and then placed the soiled towel onto the bed linens. The CNA then applied a white cream [unlabeled] to the			

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resident's bilateral buttocks. CNA #16 assisted the resident from lying on left side to back and then used wipes to clean around the resident scrotum, first down one side and then the other. The urinal was then positioned between the resident's thighs and his penis placed inside the opening of the urinal.

2. The record for Resident "F" was reviewed on 09-08-11 at 2:35 p.m. and again on 09-13-11 at 10:00 a.m. Diagnoses for Resident "F" included but were not limited to cerebral vascular accident, diabetes mellitus, syncope, and hypertension. These diagnoses remained current at the time of the record review. The resident was re-admitted to the facility on 09-12-11, after a recent hospitalization for a procedure and suffered a subarachnoid hemorrhage and upon re-admission was assessed by the nursing staff to require total care for all activities of daily living.

During an observation on 09-13-11 at 9:30 a.m., the resident was lying in bed with the head of the bed elevated and the gastrostomy tube feeding infusing at 65 c.c. per hour. During a further observation on 09-13-11 at 12:00 p.m., the resident remained on back with the head of the bed elevated as observed previously. A request was made to check

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	the resident for incontinence. Licensed Practical Nurse- Employee #25 turned the feeding pump to the off position, lowered the head of the bed, pulled the bed linens to the end of the bed, and turned the resident to the right side. Although the resident was not incontinent, the resident's buttocks were slightly reddened and had indentations across the upper thighs and hip area from the incontinent brief. 3. The record for Resident "G" was reviewed on 09-13-11 at 1:00 p.m. Diagnoses included but were not limited to lack of coordination, peripheral neuropathy, dementia, gout, congestive heart failure and diabetes mellitus. These diagnoses remained current at the time of the record review. Review of the Minimum Data set assessment, dated 06-16-11, indicated the resident required assistance with toileting as the resident was incontinent of urine. A plan of care, dated 06-17-11, indicated the resident "required up to extensive assist in performing ADL's due to impaired vision, pain to lateral knees and unsteady balance." During an observation on 09-13-11 at 12:30 p.m., CNA - Employee #7 toileted the resident. The CNA had a gait belt			

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	attached to waist. The resident was observed seated on the commode with the walker adjacent to the commode. The CNA, without saying anything, left the bathroom while the resident remained on the commode. The CNA returned to the resident's room carrying a towel and two washcloths. The CNA turned on the water at the handwashing sink and wetted the two washcloths. The CNA instructed the resident to stand up and then with the first washcloth the CNA cleansed the resident's buttocks area, wiping around the rectum, turning the washcloth and wiping again. The CNA then dried the resident's buttocks. The CNA then took the second washcloth and wiped between the resident's legs and then dried the area. 4. The record for Resident "J" was reviewed on 09-09-11 at 2:15 p.m. Diagnoses for resident "J" included but were not limited to schizophrenic condition, bipolar disorder and dementia with agitation. These diagnoses remained current at the time of the record review. During the Initial tour of the facility on 09-08-11 at 10:30 a.m., resident "J" was assessed by the Unit Manager Licensed Practical Nurse-Employee #4 as "total care." Review of the resident's plan of care,			

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	dated 08-18-11, indicated the resident required assistance with activities of daily living due total dependence for bed mobility, transfers, eating and toilet use. The resident's plan of care for Urinary Incontinence, dated 08-18-11, indicated the resident was incontinent of bladder and required the nursing staff to "approach resident at least every two hours and ask and or check for evidence of incontinence." The resident's plan of care, titled "Dental Care" and dated 08-18-11, indicated the resident "requires special attention to oral care due to edentulous <sic>, dependent on staff for oral care and impaired cognition." Interventions to this plan of care included "provide and assist with oral care daily and as needed." During an observation on 09-09-11 at 8:15 a.m., the resident was seated in wheelchair in room. The resident cried and moaned. Upon entering the resident's room, the resident's tongue/mouth was observed coated with a thick white substance. The Assistant Director of Nurses was notified, who in turn instructed a CNA to provide oral care to the resident. The CNA exited the resident's room, and returned with toothettes. As the CNA provided oral			

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	care to the resident, thick white clumps were removed from the resident's tongue and oral cavity. Further observation at 10:10 a.m., the resident remained seated in the wheelchair. A request was made to check the resident for incontinence. CNA- Employee #16 indicated the resident was "up and in the wheelchair since about 7:30 a.m." The CNA pulled down the front of the resident's slacks and indicated the resident was "dry." A request was made to transfer the resident in to bed to check skin. CNAs-Employees #14 and #16 exited the resident's room and approximately 10 minutes later returned with the mechanical lift. The CNA's positioned the lift in front of the wheelchair, fastened the appropriate hooks onto the sling that was already positioned beneath the resident, and then transferred the resident to bed. The CNA's removed the resident's slacks, unfastened the incontinent brief, and a strong smell of urine permeated the air. The resident was wearing one incontinent brief inside of the other and the inner brief was saturated and heavy with urine. The CNA's indicated they were unaware the resident had been placed in two			

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	incontinent briefs. CNA #14 exited the resident's room, entered the bathroom and returned to the bedside with two wet washcloths and a towel. CNA #16 took the washcloth from CNA #14 and washed the resident's lower abdomen in a back and forth motion and then dried the area with a towel. The CNA took the second washcloth and repeated washing the resident's lower abdomen with the wetted washcloth and then dried the area. CNA #14 assisted in turning the resident to the right side and CNA #16 used the same washcloth, wiped the resident's buttocks and then dried the area. 5. Review of policy on 09-13-11 at 12:40 p.m., titled "PERINEAL CARE [bold type and underscored], dated 01-06, indicated the following: "Purpose [underscored]: to cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image." "Equipment [underscored] May include washcloth(s), disposable wipes, towel(s), peri-wash, soap product, wash basin, gloves, bags for disposal of trash and linens (if needed)." "Procedure [underscored]: 1. Obtain necessary equipment and take			

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	to resident's bedside. 2. Explain procedure to resident and provide privacy. Drape if needed. 3. Position resident - female resident may be cleansed in supine position or in side lying position if unable to adequately access the labia from supine position due to positioning problems, contractures of legs or residents resistance to care. 4. Fill basin with warm water, if applicable, and have resident check water temperature. 5. Apply gloves. 6. Assist resident to spread legs and lift knees, if possible. 7. Remove disposable brief or pad, if applicable and place in trash bag. 8. Remove dirty gloves and apply a clean pair. 8. <sic> Wet and soap washcloth, wet and apply peri-wash to washcloth obtain disposable wipe. 9. If resident has a catheter, check for leakage, secretions or irritations. Gently wipe approximately four inches of catheter from meatus out. 10. Wipe from front to back and from center of perineum to thighs. Change cloth or wipe as necessary." "For females: a. Separate labia. Wash urethral area first. b. Wash between and outside labia in downward strokes, alternating from side to side and moving			

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outward to thighs. Use different part of cloth for each stroke."

"For males: a. Pull back foreskin if male is uncircumcised. Wash and rinse the tip using circular motion beginning at urethra. b. Continue washing down the penis to the scrotum and inner thighs."

"11. Change water in basin: use clean washcloth: use new wipe and rinse area thoroughly in the same direction as when washing.
12. Gently pat dry area in same direction as when washing.
13. Assist resident to turn onto side away from you.
14. Wet and soap washcloth or obtain wipe.
15. Clean anal area from front to back. Rinse and pat dry thoroughly.
16 Remove soiled underpad, if indicated, and assist resident to turn onto back and undrape resident, if needed.
17. Place dirty linens in bag.
18. Remove gloves.
19. Wash hands."

Review of policy on 09-13-11 at 12:40 p.m., titled "Oral Hygiene Procedure," and dated 09-05 indicated the following:

"PURPOSE: To cleanse the mouth for personal hygiene and to lessen the

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	occurrence of mouth infections." This Federal tag relates to Complains IN00095455 and IN00096396. 3.1-38(a)(3)(A)			
F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure a resident was free from pressure ulcers in that when a resident was identified as incontinent of bowel and bladder, relied on the nursing staff for repositioning needs, and was at risk for pressure ulcers, the facility failed to ensure the resident was kept clean, dry and repositioned which resulted in new pressure areas/skin breakdown for 1 of 3 residents reviewed for risk of pressure ulcers in a sample of 10. [Resident "J"]. Findings include:	F0314	1. Treatment was secured and Resident J's care plan was reviewed and revised, as indicated, relative to the newly identified open areas. Staff were immediately re-educated as to prompt incontinence assistance and necessary measures to prevent development of pressure ulcers.2. As all residents have the potential to be affected, the following corrective measures were implemented:3. As a means to ensure ongoing compliance with ensuring a resident is free from pressure ulcers, Nursing staff were re-educated on nurse aide assignment sheet use-	10/07/2011

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	During the Initial tour of the facility on 09-08-11 at 10:30 a.m., Resident "J" was assessed by the Unit Manager, Licensed Practical Nurse- Employee #4 as "total care." The record for Resident "J" was reviewed on 09-09-11 at 2:15 p.m. Diagnoses for Resident "J" included but were not limited to schizophrenic condition, bipolar disorder and dementia with agitation. These diagnoses remained current at the time of the record review. Review of the resident's Minimum Data Set assessment, dated 08-09-11, indicated the resident required total care for transfer, ambulation, dressing, eating, hygiene and incontinent needs. In addition, the assessment indicated the resident did not have a previous history of pressure ulcers. Review of the resident's plan of care, dated 08-18-11, indicated the resident required assistance with Activities of Daily Living due total dependence for bed mobility, transfers, eating and toilet use. The resident's plan of care for Urinary Incontinence, dated 08-18-11, indicated the resident was incontinent of bladder and required the nursing staff to		specifically as it relates to incontinence care and pressure ulcer prevention (see **attachments I and J**). The DON or her designee will make rounds twice daily on scheduled work days for 4 weeks, then twice weekly for 4 weeks, then weekly thereafter ensuring that residents are provided incontinence care in a timely manner and interventions implemented per the plan of care to prevent pressure ulcer development (see **attachment K**) and corrective action taken, as warranted. 4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action revised, if warranted.5. The above corrective measures will be completed on or before October 7, 2011.	

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	"approach resident at least every two hours and ask and or check for evidence of incontinence." Interventions to this plan of care included "encourage and assist resident with turning and repositioning at least every two hours. Provide incontinent care after each incontinent episode." The plan of care, dated 08-10-11, with the identified problem "risk for the development of pressure ulcers due to incontinence, spends all/lost of time in bed/chair, impaired communication, impaired cognition, and dependence on staff for transfers, repositioning and bed mobility. " Interventions to this plan of care included "apply preventative topical medication as ordered - Xenaderm every shift, provide incontinence care after each incontinent episode, encourage and assist resident with turning and repositioning at least every two hours." During observation on 09-09-11 at 8:15 a.m., the resident was observed seated in wheelchair and remained seated in the wheelchair until 10:10 a.m. A request was made to check the resident for incontinence. CNA- Employee #16 indicated the resident was "up and in the wheelchair since about 7:30 a.m." The			

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	CNA pulled down the front of the resident's slacks and indicated the resident was "dry." A request was made to transfer the resident in to bed to check skin. CNAs- Employees #14 and #16 exited the resident's room and approximately 10 minutes later returned with the mechanical lift. The CNA's positioned the lift in front of the wheelchair, fastened the appropriate hooks onto the sling that was already positioned beneath the resident, and then transferred the resident to bed. The CNA's removed the resident's slacks, unfastened the incontinent brief, and a strong smell of urine permeated the air. The resident was wearing one incontinent brief inside of the other and the inner brief was saturated and heavy with urine. The CNA's indicated they were unaware the resident had been placed in two incontinent briefs. During observation on 09-14-11 at 9:30 a.m., the resident was observed lying supine (on their back) in bed. Further observation on 09-14-11 at 12:00 p.m., the resident remained in the supine position. A request was made to check the resident for incontinence. The Licensed Practical Nurse-Employee #26 pulled the bed linens down to the end of the bed, looked at the brief and indicated			

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	the resident was "dry." A request was made to turn the resident and check the resident's skin. Licensed Practical Nurse-Employee #26 enlisted the assistance of Licensed Practical Nurse-Employee #27, and both turned the resident to the left side. The incontinence brief was unfastened and the resident was observed with two incontinent briefs on. The inner brief was wet with urine. As the resident was turned to the left side, two open areas were observed. Licensed nurse-Employee #27 verified the areas were pressure areas and measured each one. Area #1 on the right buttocks measured 1 cm [centimeter] "around and 0.2 cm. in width by 0.8 cm. in length, while area #2 located on the left buttocks/coccyx measured 0.1 centimeter "around" and 0.5 cm in width by .4 cm in length. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure the safety of residents, in that when residents had a history of falls, which included a fracture, the nursing staff failed to ensure the supervision and implementation of assist devices to alert the staff of unassisted transfers for 2 of 5 residents reviewed for falls in a sample of 10. [Residents "E" and "G"]. Findings include: 1. The record for Resident "E" was reviewed on 09-13-11 at 3:00 p.m. Diagnoses included but were not limited to fractured femur with open reduction and internal fixation, hypertension, instability of gait, and vertigo. These diagnoses remained current at the time of the record review. Review of the hospital notations, which included a "consultation note - final report," dated 05-15-11, indicated family members confirmed with the physician the resident had "multiple falls lately." An additional notation indicated the resident had "syncope with falls."	F0323	1. Resident E no longer resides at the facility. Resident G 's plan of care was reviewed and revised to ensure history of falls and applicable interventions are addressed. 2. As all residents at risk for falls have the potential to be affected, the following corrective actions were taken:3. As a means to ensure ongoing compliance with ensuring the safety of residents with a history of falls, Nursing staff were re-educated on the Gait Belt policy and procedure and the Fall Management Program (see **attachments M & N)**. The DON or her designee will review all new admissions within 24 hours of admission to ensure that should fall risk be identified, an appropriate intervention was implemented and reflected on the plan of care (see **attachment O**). Additionally, the DON or her designee will make observations/rounds twice daily on scheduled work days for 4 weeks, then twice weekly for 4 weeks, then weekly thereafter to ensuring that residents fall interventions are implemented per the plan of care, including not leaving a fall risk resident on the toilet unsupervised and utilizing gait belts with transfers (see **attachment K).** Should concerns	10/07/2011

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	The hospital "Admission H & P [history and physical] Final Report, with addendum," and dated 05-13-11, included an assessment that [family and pt. indicate frequent falls and syncope over the past yr. [year] with increasing frequency. Pt. describes both spinning and light-headedness, but today it was light-headedness primarily. History of falls secondary to light-headedness/dizziness now with right hip fracture." The "Admission Orders and Plan of Care, dated 05-23-11, instructed the nursing staff regarding "activity level: up with assist of 2." The resident was admitted to the facility in order to receive physical therapy and occupational therapy. The "new patient notification" documentation, affixed to the front of the resident's chart indicated the resident was alert and oriented with minor deficits and forgetfulness, fell outside while walking with a family member, had a history of multiple falls, vertigo and required the use of a walker and a quad cane. The Initial Care Plan dated 05-23-11, identified the resident as "at risk for falls r/t [related to] hx. of falls, recent hip fracture, decreased safety awareness and dizziness." Interventions to these		be observed, corrective actions shall be taken immediately.4. As a means of quality assurance, the findings of the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action revised, if warranted.5. The above corrective measures will be completed on or before _____, 2011.	

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	155077	A. BUILDING 00 B. WING	09/16/2011

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	identified problems included "assess and monitor gait, call light within reach, provide adequate lighting, assure proper non-skid footwear and keep walkway clutter free." The subsequent care plan, also dated 05-23-11, again identified the resident with "multiple risk factor for falls, such as history of falls, confusion and pain." Interventions included "provide adequate lighting, ensure pathways are clutter free, resident to utilize foot wear with non-skin <sic> soles, monitor the resident frequently when the call lights are not available (i.e. dining room, activities, etc...), complete fall risk assessment upon admission, quarterly and with any significant change, monitor vital signs as indicated, neurological checks as indicated, notify responsible party and MD [Medical Doctor] if a fall occurs, [BOLD TYPE] - Implement interventions to reduce risk for falls: (list interventions and date initiated), 05-23-11 PT/OT eval and tx. 05-23-11 assist with ADL's [activities of daily living], 05-26-11 bed alarm." Review of the 5 day Minimum Data Set assessment, dated 05-30-11, indicated the resident required extensive assistance with bed mobility, transfer and toileting, and was unable to "steady self only with			

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	human assistance in regard to moving from surface to surface or moving from a seated position to a standing position. The assessment indicated the resident was frequently incontinent of urine and occasionally incontinent of bowel. The fall risk assessment, dated 05-24-11, indicated the resident had a "history of falls, used assist devices, had confusion, weakness, poor vision, an unsteady gait, and use medications which included narcotics, antihypertensives and diuretics. The Physical Therapy Evaluation, dated 05-24-11, indicated the resident was "non-ambulatory at this time" and at "risk for falls." In addition the evaluation indicated the resident was "alert" but "confused" and required maximum assist with changing positions from a lying position to standing, sitting to standing, bed to wheelchair and had "poor" balance with sitting and standing. Review of the Occupational Therapy Evaluation, dated 05-24-11, indicated the resident's "safety awareness" was "impaired." The notations from the mental health specialist, dated 05-25-11, indicated the resident was "referred to psychology service due to poor adjustment to			

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	placement , depression, anxiety, disordered thinking and recent altered mental status. Current s/s [signs and symptoms] include auditory/visual hallucinations ... pt. reports both visual and auditory hallucinations. pt reports seeing portraits of men's faces on her wall and that they follow her with their eyes, wink at her, smile etc. Per staff, pt. has a long hx of mental health issues. Pt. seems aware that hallucinations are not real events." Review of the nurses notes indicated the following: "05-23-11 at 7:10 p.m. Pt. [patient] admitted from [name of local area hospital] ... alert to self, does not know time or place, grips weak. Pt. unable to move right leg due to fx. [fracture]. pt. has staple in right hip, ... unable to stand or sit up by self..." "05-24-11 4:15 a.m. arouse easily - alert to name, confused to time and place." "05-26-11 at 5:00 a.m., "Res. [resident] found sitting on floor next to bed. res. stated she was attempting to get out of bed per self. 2.2 cm [centimeter] by 2.8 cm abrasion noted to left mid back." Review of the Social Service Assessment, dated 05-25-11, indicated the resident			

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	conveyed to the staff member of "dizziness over the last several days, dizziness worse with sudden movement. Resident had fall at home to right side. Family report multiple falls recently. Resident suffered right hip fracture. Resident has a hx. [history] of mental health issues with visual hallucinations and depression." During an interview on 09-14-11 at 11:40 a.m., the Unit Manager, Licensed Practical Nurse -Employee #2 indicated "If a resident had been at the hospital due to a fall I try to put a bed sensor on the bed as a precautionary measure." When interviewed, the nurse indicated she did not need a physician order to place a sensor monitor on a bed/chair to alert the staff of unassisted transfer or ambulation. The nursing staff failed to implement an assist device to alert the staff of unassisted ambulation/transfer for a resident with a history of falls, confusion, poor vision, visual/auditory hallucinations and vertigo. 2. The record for Resident "G" was reviewed on 09-13-11 at 1:00 p.m. Diagnoses included but were not limited to lack of coordination, peripheral neuropathy, dementia, gout, congestive heart failure and diabetes mellitus. These diagnoses remained current at the time of			

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	the record review. Review of the Minimum Data set assessment, dated 06-16-11, indicated the resident required extensive assistance with dressing, bed mobility and transfers. The resident was also assessed with incontinency of urine. The resident's care plan, dated 06-17-11, indicated the resident was "at risk for falls," and the intervention indicated "non skid strips in bathroom." A plan of care, dated 06-17-11, indicated the resident "required up to extensive assist in performing ADL's due to impaired vision, pain to lateral knees and unsteady balance." The fall risk assessment, dated 06-22-11, indicated the resident had a history of falls, required the use of an assist device, had confusion, weakness and an unsteady gait. The physician progress notes, dated 09-06-11, indicated the resident had lower extremity edema, with family concern that the resident is not on any diuretic. During an interview on 09-09-11 at 8:30 a.m., a concerned family member indicated recently when the family			

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	member arrived at the facility, the resident was found seated on the side of the bed, without anyone helping [name of resident]. "[name of resident] could have fallen, where was the staff and how could they have left [resident] alone like that ? I spoke with the Administrator about it and gave him a piece of my mind. I know it better never happen again." During an observation on 09-13-11 at 12:30 p.m., a CNA [Certified Nurse Aide] -Employee #7 toileted the resident. The CNA had a gait belt attached to he own waist and not the resident. The resident was observed seated on the commode with the walker adjacent to the commode. The CNA, without saying anything, left the bathroom while resident remained on the commode. The CNA returned to the resident's room carrying a towel and two washcloths. The CNA performed pericare adjusted the resident's clothing and instructed the resident to stand up. With difficulty, the resident stood and the CNA moved the resident from in front of the commode to a wheelchair without the use of a gaitbelt. 3. Review of the facility policy on 09-13-11 at 12:40 a.m., and titled "Gait Belt Procedure," dated 09-05 indicated the following: "PURPOSE [bold type]: To insure <sic>			

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	safety in transfer and ambulation. To provide a point of contact and increased support from the staff and prevent injuries to staff and resident's who are unable to transfer or ambulate independently." 4. Review of the policy on 09-14-11 at 9:40 a.m., titled "Fall Management Procedure," and dated 02-05, indicated the following: "PURPOSE [bold type] To assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team, as appropriate, for resident use in maintaining or returning to the highest level of physical, social and psychosocial functioning as possible." "PROCEDURE [bold type] 1. Complete the fall risk assessment and care plan upon admission, readmission, quarterly and with significant change in status. 2. The interdisciplinary health care plan team will review the risk factors and determine if further assessment is needed. 3. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls and/or injuries related to falls." This Federal tag relates to Complaint IN00096044.			

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	3.1-45(a)(2)			